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FOR THE PHYSICIAN IN GENERAL PRACTICE

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PINEL

the psychiatric bulletin

for the physician in general practice

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The Cover

- The cover drawing, by Joseph F. Schwarting, pays tribute to Philippe Pinel (1755-1826).
- Pinel deplored the chains, squalor, neglect, and indignity forced upon the mentally ill in the late 18th century in Revolutionary France. Even though he was, reportedly, attacked by a mob, he obtained permission from the government to remove the chains, prohibit admission of curiosity-seekers, and improve the patients' living quarters. In addition, Pinel separated patients according to the degree of disorder, classified mental illnesses, introduced the psychiatric case history, provided occupational therapy, and was author of an important treatise on mental disease.

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CONTENTS

Anorexia Nervosa in Children

● PATHOLOGIC FAILURE of appetite that is emotionally caused is called *anorexia nervosa*, classified by the American Psychiatric Association as a psychophysiologic gastrointestinal reaction. This disorder amounts to much more than the usual "feeding problem" which is familiar to all physicians and most parents. Indeed, the most significant aspect of anorexia nervosa is the seriousness and gravity of the condition which is actually known to jeopardize life. To the patient, food has acquired a symbolic and unrecognized meaning which forces him to fear and to reject nourishment. Although the disorder is relatively uncommon, both psychologic and physical therapy are essential in every case, as about eight per cent of cases are fatal.

Emaciation and pallor characterize anorexia nervosa. The patient's history usually includes progressive and conspicuous weight loss and gastrointestinal malfunction. Amenorrhea and hair loss occur in older patients. The systolic pressure, basal metabolic rate, and body temperature are lowered, and protein and vitamin deficiencies sometimes develop. Water intake is less. Starvation edema and bradycardia have been reported, and, occasionally, syncope occurs as a result of the decrease in the blood sugar levels.

Etiology of anorexia nervosa is still obscure, although emotional causation has been established. Presumably, in the early relationship between child and mother a chronic state of dependency is initiated. Loss of appetite and ruthless self-starvation can be interpreted as attempts to regain unity with the mother. The emotional components of food choice and of eating habits are many and complex, and the sexual connotations well-known. Meyer and Weinroth point out, however, that hysterical loss of appetite at puberty in response to psychosexual change is clinically familiar and greatly differs from anorexia nervosa in pathogenesis, gravity, and in the therapy required.

In children, insecurity is demonstrated in varying ways, and appetite loss, like obesity, results from emotional conflict. Insecure or neurotic parents have ambivalent feelings about their children so that their behavior to the children is inconsistent and capricious. In the offspring, efforts to please the parents or to comply may take the form of disordered eating. The individual symptom of anorexia nervosa is developed in children of hostile parents, and because the parental attitude toward food may actually amount to withholding it, the child of such parents comes to find food repulsive. Often patients with anorexia nervosa have previously been obese. In this sequence, efforts to diet become uncontrollable and they literally starve.

Significance of anorexia nervosa

Physicians comment upon the apathy of anoretic patients, and their appearance of preoccupation and disinterest. Both reticence and manic activity become evident. It is of immediate importance that the disorder be recognized for what it is and not ascribed to pituitary disorder or to hysterical conversion. Clinically and on laboratory tests there is, of course, a resemblance to Simmonds' disease (cachexia hypophysiopriva), and after a period of inanition the pituitary body is ultimately affected. Actually, starvation is known to depress all endocrine function. Besides this, it is also important that the physician be fully aware of the seriousness of the complaint. Although these patients are usually exceptionally active despite physical debility, they are also likely to die suddenly, without any additional indication that death is imminent. The emaciation and tissue wastage of anorexia nervosa can be much more extreme than would be tolerated by the body in actual famine. In an instance cited by Keys, the body of a 16-year-old

girl was measured after death. The cadaver was 64 inches in length and the body weight was 49 pounds.

It is obvious that initiation of therapy should be immediate. At one time it was considered best to hospitalize all patients with anorexia nervosa, but not all investigators agree to this. Feeding by force and administration of vitamin supplements are unrewarding except as temporary life-saving measures, because in such procedures nothing at all is done about the precipitant situation. Forced intake, according to Aldrich, actually reinforces the patient's guilt. The physician must in effect become a substitute parent for the treatment period to a patient whose dependency needs have brought him to this condition. The patient is unconsciously suicidal, within the pattern of compliance, because a parent—usually the mother—has expressed without words an unadmitted wish for the patient's death. The parent whom Frazier describes as "murderously ambivalent" has invoked self-destructive neurosis in the offspring. The suicidal wish of the child has to be expressed somatically; the natural physiologic expression becomes manifestly chronic; and the emotional component is repressed. In time, the structure of the viscera is affected, as in most of the so-called psychosomatic disorders.

Therapy

According to Giffin and others, in the acute stages the preferred treatment combines a medical regimen with supportive psychotherapy. If results are unsatisfactory prompt psychiatric referral is indicated. In the opinion of these individuals the patients while in the acute phase should receive positive support "at whatever psychological level necessary." Giffin and associates have reported successful establishment between the physician and the anoretic patient of a supportive relationship in this fashion. The procedure is initiated with the case history. Highly detailed information is elicited and recorded in protracted interviews. Actually, in cited instances, they occur for periods of one to two hours on successive days. During this close questioning, the symptoms of anorexia nervosa are explained, the diet intended is outlined, anticipated increase of weight stated, and acceptable activities named and recommended. The parents may be included in these interviews, at which time the physician answers questions, describes comparable instances of the disorder, and restates his program.

In the expected transference situation the physician as substitute parent is authoritative, hopeful, and encouraging. During this phase he directs all dietary programs, and intravenous parenteral fluids and salt regulation are not utilized. The diet is one of steadily increasing caloric content, and probanthine may be administered before meals to alleviate gastric spasm. The dietitian as mother figure only proffers the food. She neither suggests nor interferes. The idea is not that of eating to excess but of ingestion only in amounts that are comfortable. The experiences of other patients are reintroduced at this period of therapy with multiple purpose: pictures of emaciated patients have surprise value and induce realistic acceptance of changed appearance; a stimulus to competition is afforded; and there is also the factor of experience shared with others who have been helped by this particular means.

As the anoretic patient has unknowingly worked at destruction of the body-image, this concept is sensibly utilized in treatment. Berkman, in the Mayo Clinic Group, discusses physical appearance with patients, does not conceal repulsion, exhibits photographs of other such patients, and makes the subjects admit the facts of their own personal appearance. He firmly maintains a hopeful attitude, however, and, in that way, denies excessive pity and prevents regression. This part of therapy is extremely important because, shortly after patients resume adequate diets, the edematous changes that occur are often frightening to the unprepared. The authors comment that as a patient's appearance improves, his need for the physician as father decreases.

During therapy, introspection, inactivity, and withdrawal from society are discouraged. The physician is helpful and approving but he consistently attempts to prevent regressive activities and to eliminate the secondary gain inherent in symptom development. With the parents, as with the patient, the entire emphasis is on "anaclitic treatment" and not on the admission of conflicts required by analysis. Actually the physician in this therapeutic situation not only takes on the care of the sick child but he also ameliorates the anxiety and guilt of the parents.

Conclusion

Anorexia nervosa is sufficiently uncommon that in a thirteen-year period only 117 cases were reported from the Mayo Clinic. This symptom complex is, nevertheless, a serious one. While spontaneous regression does sometimes occur, the disorder is also known to be fatal. Emotionally induced appetite loss has been termed an "organ neurosis," but, according to Kraft, no neurosis is known to be specific to its development. Many therapeutic measures have been tried in cases of anorexia nervosa, among which are anterior pituitary extract, insulin and electroshock, psychoanalysis, desiccated thyroid extract, leucotomy, steroid therapy, and psychotherapy. A medically supervised diet program with adjunctive psychotherapy probably offers the best chance of cure except in cases of extreme psychoses. The important factors are that the disorder be identified promptly, the potential danger fully evaluated, and immediate treatment begun.

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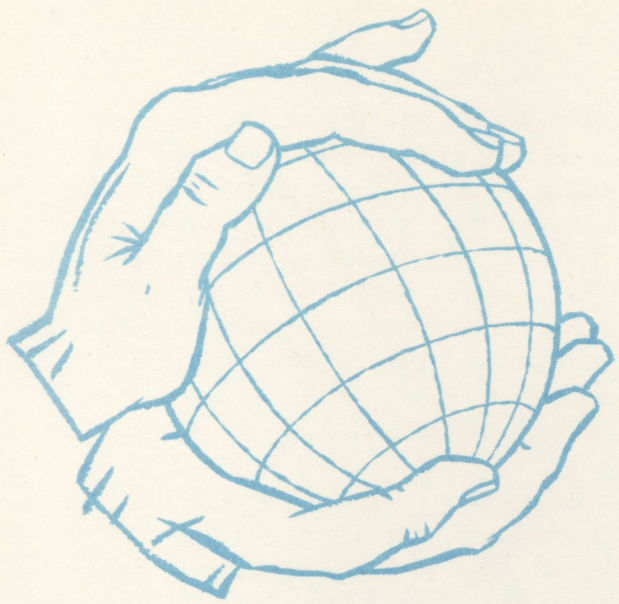

Drug Addiction

Most persons are, at some time during their lives, given an analgesic, a sedative, or a stimulant that has addictive properties. It may be prescribed as a single dose, or in dosage to be taken for a longer period. Usually, however, when the need for which the drug was given has been resolved, the individual discontinues its use. In contrast to this normal management of pharmacological therapy is the compulsive misuse demonstrated by the addict. According to Rado, one experience of the effects of a narcotic drug is often sufficient to establish uncontrollable craving in the predisposed individual. This observation may be correlated with Fenichel's statement that ". . . the origin and the nature of the addiction are not determined by the chemical effect of the drug but by the psychological structure of the patient." Fenichel described addiction as a form of pathological impulse, similar to kleptomania or pyromania, for example. To the addict, the drug has a special significance. It provides an equivalent of sexual gratification, and feelings of security and self-esteem. These reactions are, however, experienced in the infantile form of passive-narcissistic oral satisfaction.

Further corroboration of greater psychological and lesser physiological dependence has been noted in the response of the addict after withdrawal symptoms have ceased. Even though he no longer suffers physical discomfort, he will, immediately or eventually, return to the state of dependence upon whatever drug satisfies his emotional need. Indeed, Wikler and Rasor stated that the distress of abstinence may be interpreted by the addict as expiation of guilt, after which atonement he is free to continue. The addict resumes drug-taking despite the knowledge that he may endure unpleasant side-effects, financial burden, loss of other forms of satisfaction, and loss of meaningful personal relationships.

In explanations of this phenomenon, the premorbid personality seems the significant factor. The potential addict is described as an immature, impulsive individual who is intolerant of frustration, evasive of responsibility, and unduly fearful of pain. He has a limited concept of reality and a distorted idea of social values. Pronounced feelings of inadequacy, unworthiness, and inferiority are characteristic, although, in some cases, they are masked by an arrogant manner. The potential addict manifests overly strong dependency needs, but, in selecting persons to help him, he frequently chooses individuals equally maladjusted.

Nyswander remarked that since the premorbid personality structure of an addict is also observed in nonaddict populations, some other factors must also be instrumental. She suggests that addiction may be a form of avoidance mechanism, such as, specifically, avoidance of sexual relationship, of aggression, or of adult responsibility. According to Nyswander, addiction frequently begins in late adolescence or early twenties, continues through the years in which sexual activity, normal aggression, and assumption of responsibility would be greatest, and diminishes as the addict nears the age of fifty. This pattern may be one of coincidence or it may be suggestive of underlying motivation of avoidance.

In order to determine why some individuals are particularly vulnerable, addicts have been queried about what result it is that they expect from drugs. The answers included restoration of self-confidence, elimination of despondency, induction of a sense of well-being or elation, and, in some instances, simply maintenance of normalcy. Another frequent answer is that the desirable state is achieved quickly without any individual effort on the part of the consumer.

From such answers, Rado has formulated a theory of the psychodynamics of drug addiction. The infant's first self-image is that of an omnipotent being for whom other persons exist only to serve. Normally, as the individual matures, this concept is adjusted to reality and an adaptable method of self-government is established. If the adaptation is not successful, the individual may attempt to revive features of his earlier status. This method is also unsuccessful, since it is incompatible with reality. According to Rado, the addict does achieve the original feeling of omnipotence by means of drugs, and, admittedly, this is a transitory effect which is always followed by depression and self-devaluation. Therefore, in order to maintain the grandiose image, he must shorten the periods of self-depreciation by more frequent doses. The craving thus becomes established. Concomitant development of tolerance necessitates an ever-increasing amount of drug, which, in turn, causes greater tension and associated physical ills. Although aware of the side-effects, the addict continues, because, with a drug-induced feeling of power, he can actually believe himself to be invulnerable. He can contemplate his own destruction with equanimity because he cannot believe it could happen.

It has been pointed out that one reason for difficulty in rehabilitation of drug addicts is that such individuals do not wish to relinquish their chosen method of prompt gratification. Addicts find greater satisfaction in the immediate attainment of self-confidence, and cannot tolerate the more lengthy work-and-reward process of nonaddicts.

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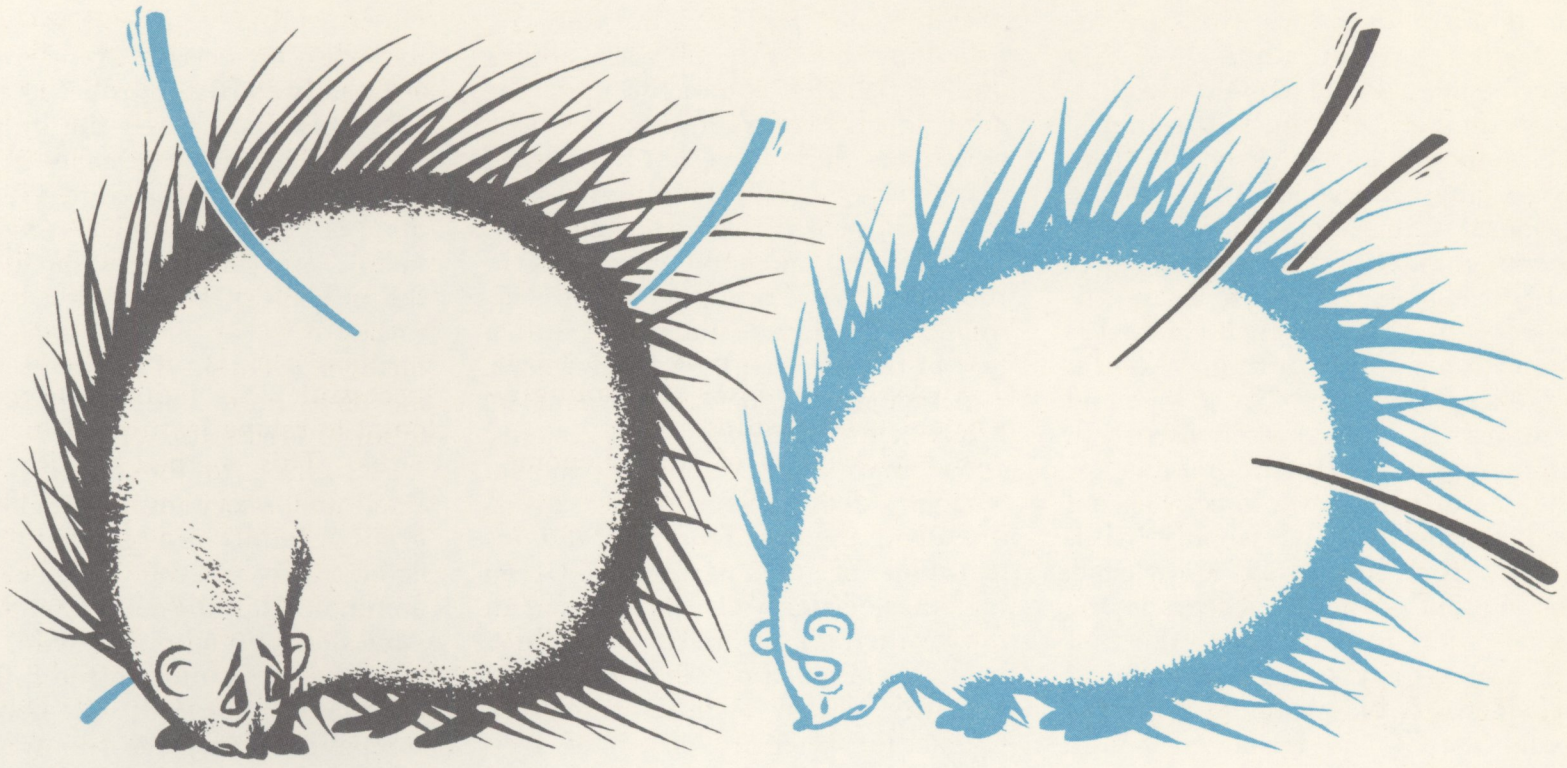

Neurotic Interaction in Marriage

● Like Jack Sprat who could eat no fat and his wife who could eat no lean, some neurotics achieve a permanent marital relationship because of their interdependence, developed on the basis of their neurotic needs. Normal individuals, on the contrary, even though well-adjusted to society, may find it advisable to terminate their marriages because of personality conflicts. In some marriages, according to Lawrence Kubie, conflicts exist because of the masked neurotic traits which affect the selection of a marriage partner. Often, a person will choose an individual with qualities which he ostensibly rejects as unsuitable or even repulsive. Thus, a passive-dependent male, while protesting the over-aggressiveness of his wife, may have chosen her for that particular quality which he needs, because of his own dependency.

Similarly, a girl who has been deprived of a father at an early age or who was deeply dependent may select a husband much older than herself in an unrecognized effort at replacement. Such substitutions are rarely successful, either because the girl matures and tends to revolt against the relationship, or because her husband was, comparably, seeking a mother figure. In other words, individuals seldom know what they really are looking for in marriage, and, before marriage, neurotic conflicts cannot always be detected. The term "matchmaking" has a new connotation when considered as the matching of interlocking needs.

The probability of a successful marriage can, sometimes, be indicated on the basis of personality tests, according to Piotrowski and Dudek, if the tests are cautiously interpreted and correlated with other clinical data. These investigators compared the Rorschach patterns of 55 couples, 33 of whom remained together, and 22 of whom were divorced. A satisfactory marriage is suggested by parallel scores at different levels or by similar distortions in thinking. Excessive and deviant scatter, however, connotes a doubtful prognosis, as does what the experimenters call "killing competition." Competition in ego-achievement results from a pattern of abilities, interests, and ego-needs that are similar, and are not recognized as the source of conflict.

The complexity of mechanisms by which the individual relates himself to the world and the part he imagines for himself were found to be of equal importance with pattern comparisons in prediction of the success of a marriage. Obviously, the man who sees himself as a little boy who comes home each evening to a welcoming mother would find the attitudes and demands of a career woman intolerable. In any marriage a significant discrepancy in intellectual complexity between husband and wife will make communication difficult, and consequently the chances for a satisfying relationship are diminished.

Freud explained that the neurotic elements in personality consisted of

fixations at various levels of development. He said, "To ensure a fully normal attitude in love, two currents of feeling have to unite—we may describe them as the tender, affectionate feelings and the sensual feelings."

A man who has in early youth received the impression that sexual response is unseemly in a virtuous woman may choose an unresponsive wife, or may encourage such an attitude because, to him, such conduct is suitable only for prostitutes. According to Freud, the inability to love and to desire the same person occurs in instances in which the mother or sister as original love object has not been superseded, and is only withdrawn from conscious knowledge. The masculine need to degrade the sexual object corresponds to the condition, necessary to some women, of forbiddenness in erotic love. Since sexual activity is forbidden before marriage some women are unable to make the immediate transition to acceptance of the sexual relationship after marriage. Such individuals may attain sexual gratification only with a lover, because they expect or require the quality of the forbidden.

In Freud's differentiation of the neurotic choices of love objects, one is exemplified by the man who never chooses an unattached woman because of his need of an injured third person. Another requires for love object a woman who has been more or less discredited. The first of these neurotic lovers gratifies a need to feel enmity, the second a need to be jealous. A lover of either type is fixated at infantile tenderness for the mother. Sometimes such a person is involved in a series of amatory experiences, none of which can be adequate, as each represents an attempt to replace the mother image.

Sexual inadequacy as a marital problem is nearly always psychic in origin and generally occurs because of some association of the wife with a forbidden incestuous love object, the mother or sister. If such conflicts have not been resolved in early youth, a single trait in the marital partner reminiscent of the forbidden woman can cause impotence. Actually, neurotic individuals can and do make satisfactory marriages, while many relatively well-adjusted persons may contract discordant ones. Eisenstein says that marriages of neurotics recall Schopenhauer's fable of the freezing porcupines, who, whenever they huddled together for warmth, were repelled by the sting of each other's quills. Benedek comments upon the antagonism concomitant to love, which she finds to be not as much a negation as a representation of the biological polarity between the sexes. Ambivalent emotions may exist in romantic love, since much of the personality is effaced and as a result a fear of the dominant person develops.

Although the degree of neurotic behavior in a marriage is not the only determinant of stability, marital harmony does depend in large measure upon the ego maturity and integration of the partners. Green lists these criteria of ego function in the evaluation of marital stability: object relationships and degree of empathy; reality testing, or recognition of the intensity of others' feelings and of actual situations as opposed to fantasy; ability to learn and judge from experience; the flexibility with which the individual meets life situations; tolerance for frustration; affectivity; defense mechanisms; and basic intellective capacities.

Clinicians and case workers generally agree on five considerations. First, the person who comes to an outside agency for help in problems of marriage shows "discoverable concern" about his situation. Second, recognition of behavior as based on emotional tensions or needs effects a change of attitude. Third, marital discord is often a symptom of other personality conflicts. Fourth, the case worker's objective must be to aid in establishing the greatest possible harmony within each personality. Fifth, it must be the client himself who decides to struggle for personal change.

Regensburg has classified kinds of marriages, and the first is one in which the tensions are consciously or unconsciously gratifying. Such unions are characterized by mutual dependency for support of neurotic needs, and the resultant pattern is one of living in conflict. Treatment consists of a restoration of the old pathologic balance, since ego-immaturity makes resolution of conflict impossible. In another type are the marriages in which change is desired by both persons because the tensions are intolerable. Treatment, in such cases, may result in a satisfactory continuance of the marriage or in dissolution. Then, there are the marriages in which mutual gratification has been disturbed by a crisis. Here, treatment ordinarily consists of relief of external pressures that caused the imbalance. Lastly, there are marriages in which, despite physical proximity, each individual has remained remote, detached, and narcissistic, but in which the unhealthy balance has been disturbed by change, sometimes by the birth of a child. Treatment in such instances helps both adults to adapt to an altered situation.

According to the classification of Buell and associates, Lidz notes three types of family disorganization, characterized by schism. These are man-dominated families, in which the husband needs an admiring wife, but the wife is disappointed in the father figure that she married; wife-dominated competitive marriages, in which the wife excludes the passive and masochistic husband from leadership because of her own narcissistic needs; and dual immaturity dependency situations, which usually result in withdrawal and subsequent dependency on members of the parental families.

Obviously, in neurotic marriage, even if a precarious balance is maintained, the children will suffer some ill effects from the imbalance or maladjustment. For instance, similar conditions were found to exist in every case study of schizophrenia reported in detail by Lidz and associates. There is, then, not only the obvious neurotic to consider. Interaction in marriage may be salutary or crippling, and children may demonstrate the results of connubial neurosis.

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Frieda Fromm-Reichmann

● Frieda Fromm-Reichmann was born October 23, 1889, in Karlsruhe, Germany. She received her degree in medicine from the University of Munich, did graduate study there, and also studied at Basle and Berlin. During the First World War she was engaged in research at Konigsberg Hospital for Brain-Injured Soldiers. She came to America in the nineteen-thirties and was Assistant Physician, Supervisor of Psychotherapy, and then Consultant in Psychotherapy at Chestnut Lodge Sanitarium in Rockville, Maryland. She was chairman in 1948 of the Council of Fellows of the Washington School of Psychiatry, and was on the staff at Chestnut Lodge until her death in 1957.

Fromm-Reichmann stressed the importance of the attitudes, insights, and needs of the therapist as factors in the therapeutic process, emphasizing the necessity that the therapist be free from anxiety and from self-disparagement. The therapist, she insisted, must realize that he is not called upon to guide such individuals toward adjustment in the sense of conformity to the conventionalities of the culture. Failure of therapists to recognize this truth is responsible for the fact that so few schizophrenics recover sufficiently to re-enter society. Fromm-Reichmann was strikingly successful in restoring to society even those schizophrenics who had been for years in trance-like states. She made a major contribution to the change in therapeutic attitude because of her assertion that schizophrenia is not so much withdrawal of interest from the environment, as loss of ability to communicate.

Fromm-Reichmann proved in her practice that a person may emerge from schizophrenia not merely as a healthy member of society but as an artist of rank. Such an artist converts into assets what had been liabilities, and communicates in an art form acceptable to our society what he had been unable to express in other ways. In support of her position, Fromm-Reichmann cited the case of a young South American woman who suffered for years from schizophrenia of the catatonic type, underwent intensive psychotherapy, and re-entered society as a major poet. Underlying the successful therapeutic relationship established by Fromm-Reichmann was the pre-supposition that the patient as an individual was worthy of respect, and that she in particular, as therapist, and other healthy-minded members of society could learn valuable facts about our culture and its pressures from schizophrenics and other mentally disturbed individuals. She suggested that mentally disturbed patients actually hold before our culture a mirror of honesty which reveals the compromises of hypocrisy.

The longing of the schizophrenic for interpersonal contact is approximately equal to his fear of it, Fromm-Reichmann pointed out, and this balance between contradictions results in the dilemma of schizophrenia. For the purposes of psychotherapy immanent values are presupposed. These values include development, maturation and inner independence of the patient, potential freedom from fear, anxiety, greed, envy, and jealousy in relations with others, self-realization, and the development of capacity to give and accept mature love. Fromm-Reichmann thought of self-realization as an important source of human fulfillment.

She studied with Sigmund Freud, Kurt Goldstein, George Groddeck, and Harry Stack Sullivan, although she disagreed with the teachings of classical analysis that people are born to be hostile and aggressive, and diverged from Freud's doctrine of the ubiquity of the Oedipus complex. She specifically acknowledged the importance of Sullivan's operational interpersonal conceptions as an influence in her scientific orientation concerning the nature of and the procedure for intensive psychotherapy.

Fromm-Reichmann made major contributions both to the theory and to the practice of psychotherapy, and was the recipient, in 1953, of the Adolf Meyer Memorial Award. She saw schizophrenic symptomology as a defense against anxiety and approached it therapeutically from this point of view. She commented that the fear of loneliness was a fate common to psychotherapists too, and believed that any further development of psychoanalytic and psychodynamic theories and therapeutic techniques would have to come from increased understanding of anxiety.

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PARKINSONISM

EXTENSIVE STUDIES have been made of the etiology, pathophysiology, and therapy in the syndrome described by Parkinson 140 years ago. Investigations have included study of the premorbid personality, the emotional problems which may occur during the prodromal stage, and the need for supportive psychotherapy for treatment of patients with fully developed Parkinsonism.

Premorbid personality

Booth described a specific personality structure as characteristic of individuals with Parkinsonism. In a study of 66 patients, the most outstanding quality was a pronounced aggressive drive toward physical action. Industriousness was a prominent feature, as well as a need for independence from outside interference, for personal authority, and for success. In addition, the behavior pattern was one of rigidly moralistic conduct. Each patient had identified with the dominant parent, or surrogate, and each had adhered to the social values learned in childhood. Since the need for independence was sometimes incompatible with social conformity, anxiety and tension were not uncommon. Hostility was suppressed because it was not consistent with the ideal of successful performance. Success became a secondary aim only in situations in which moral or altruistic factors were considered more important. Booth also reported an unusually high incidence of claustrophobia, which he attributed to anxiety about loss of freedom.

There has been some dissent with respect to designation of a particular personality type in Parkinsonism. For example, Prichard and associates classified 100 patients with Parkinsonism into three groups according to personality. There were 48 patients in the first group, who were described as calm, realistic persons who adapted well to life situations. Thirty-three patients in the second group were dependent, submissive, and suggestible. These patients were cooperative, and observed closely the therapeutic regimen. The third group of 19 patients had characteristics similar to those described by Booth. They were governed by unusually high standards, and showed great ambition and drive toward accomplishment. The authors concluded that there is no single personality type which is peculiar to Parkinsonism. In their opinion, it is important to recognize different types because of the varied somatic reactions to emotional stress in the course of the disease. For example, disease was exacerbated by stress in only twelve per cent of the first group, 21 per cent of the second, and in 58 per cent of the third.

Prodromal stage

The period immediately preceding development of tremor may be especially difficult for the patient. Differential diagnosis may be problematic, also, as some of the early symptoms are similar to those frequently ascribed to specific psychogenic disorders. An early sign of Parkinsonism is decreased motor activity, especially the ability for fine or precise movements. Since activity may be, characteristically, the chief method of expression, interference with motor ability causes distress, confusion, and misunderstanding until the patient knows the reason for slowed movement. Poverty of movement is also demonstrated in such simple performances as sitting, rising, and walking. In addition, pre-Parkinsonian patients frequently complain of pain which is described as a dull ache in the regions of muscle masses. Diagnostically, this may be confused with arthritic, neuritic, or psychogenic disorder. According to Forster, differential diagnosis will depend upon astuteness in observation of the prodromal manifestations.

There is little difficulty in distinguishing fully developed Parkinsonism. In addition to pronounced tremor, there is the characteristic posture which has been compared to that of a boxer. A propulsive gait may be noted in some cases. The patient hurtles forward until stopped. Some investigators consider these symptoms to be demonstrations of aggression. Lateral or posterior propulsion is less common. Increased salivation

frequently results in drooling. According to Booth, however, the patient with Parkinsonism is able to swallow excess saliva; the fact that he does not is attributed, by this investigator, to feelings of hostility.

Reactive and related mental disorders

In addition to the classical symptoms of Parkinsonism, reactive mental disturbances and related paroxysmal psychiatric disorders may be manifested. In a five-year study of more than 200 patients, Schwab and associates reported that reactive mental disturbances are most likely to occur in persons who have previously shown serious mood changes with any stress situation. The reactions include depression, worry, overconcern with symptoms, insomnia, irritability, and pessimistic outlook. These reactions could, of course, occur with any chronic illness and are not specifically related to Parkinsonism.

Psychiatric disorders which do seem to be related to Parkinsonism are distinctive because of their self-limited duration, and, in some instances, their bizarre nature. These disorders are usually associated with oculogyric crises, and attacks may last from a few minutes to 24 hours. There may be, for example, an acute anxiety reaction, with tachycardia, hyperhidrosis, respiratory changes, and alterations in vasomotor tone. The patients describe a feeling of terror and a sense of imminent catastrophe. One patient, who had had no previous history of mental disorder, experienced attacks which lasted from 20 to 30 minutes. She stated that when an attack ended she always felt surprised that no untoward event had taken place. This patient was greatly relieved to learn that the attacks were part of the Parkinsonism, to which she had already become well-adjusted.

A second type is that of compulsive repetition of words or numbers. For instance, one patient repeated the same date without interruption for half an hour. The date was a future one, and had no significance of which the patient was aware. Although she was curious and amused by the manifestation between attacks, during them she was distressed by the uncontrollable repetition.

Episodes of profound depression may also occur. These may be momentary or may last as long as an hour. Suicidal thoughts are not uncommon, and actual suicides have been reported in such patients.

Paranoid attacks have been observed in which hostility toward the environment was noted. Occasionally, the paranoid thoughts relate to the direction in which the eyes turn during oculogyric crisis. For example, one patient experienced crises in which his eyes were drawn to the left. During an attack, he believed that objects and persons to his left were hostile and that those to the right of him were friendly.

Other types of reaction have been cited which include schizoid manifestations, severe agitation and tension, and chronic fatigue states that were disproportionate to the amount of tremor. In all of the cases of psychiatric disturbance related to Parkinsonism, the patients had not experienced previous mental disorder, were emotionally well between attacks, and, in many instances, the episodes ceased after psychotherapy or change in medication.

Supportive psychotherapy

Supportive psychotherapy is a necessary adjunct to medical treatment of patients with Parkinsonism. Emotional stress is known to intensify severity of the symptoms. Inability to perform simple functions results in a feeling of helplessness and fear of dependency. This is especially disturbing to the patient whose concept of success is based upon active accomplishment. Commonly, patients attempt denial of illness as a method of prevention or management of distress. This method cannot be effective, of course, partly because the disorder is conspicuous. As a result, the patient becomes depressed, and, frequently, fails to adhere to a therapeutic regimen. A cycle of depression, inadequate treatment, lack of improvement, and increased depression is thus established.

Several principles have been cited as guides for supportive psychotherapy. First, the patient has a tendency to identify with authority. This provides the most satisfactory basis for physician-patient interaction. The patient does not respond as well to subjection and dictatorial instruction. In the latter situation, conflict may exist because of the patient's need for conformity and his resentment of interference. This is illustrated by the patient's walking easily with the support of a light touch on his hand, although he is impeded when his arm is grasped firmly.

The patient must be helped to understand that physical activity, although not precluded, may be engaged in only to the degree of relaxation. Generally, such activities as swimming, simple ball games, or dancing are more beneficial in this respect than are competitive games or gymnastics. Many patients attempt to control tremor by maintenance of muscle tension, which mechanism simply increases the tremor; therefore, relaxation is emphasized, and the patient is encouraged to keep physical exertions below his limits of capability.

Supportive psychotherapy is most significant when the patient has reached a point in physical endeavor beyond which he cannot progress. At this time, he may experience intense frustration and shame because of physical limitation. Characteristically, the Parkinsonian patient would then drive himself, against insuperable disadvantage, to greater physical activity. This results in increased anxiety, frustration, and emotional conflict, as well as exacerbation of the disease process. In order to avoid this sequence, the patient may be directed toward accomplishments which require mental instead of physical activity. With adequate guidance, the Parkinsonian patient can learn to accept passivity without guilt and failure without shame, and will be able to compensate for physical disability by intellectual successes.

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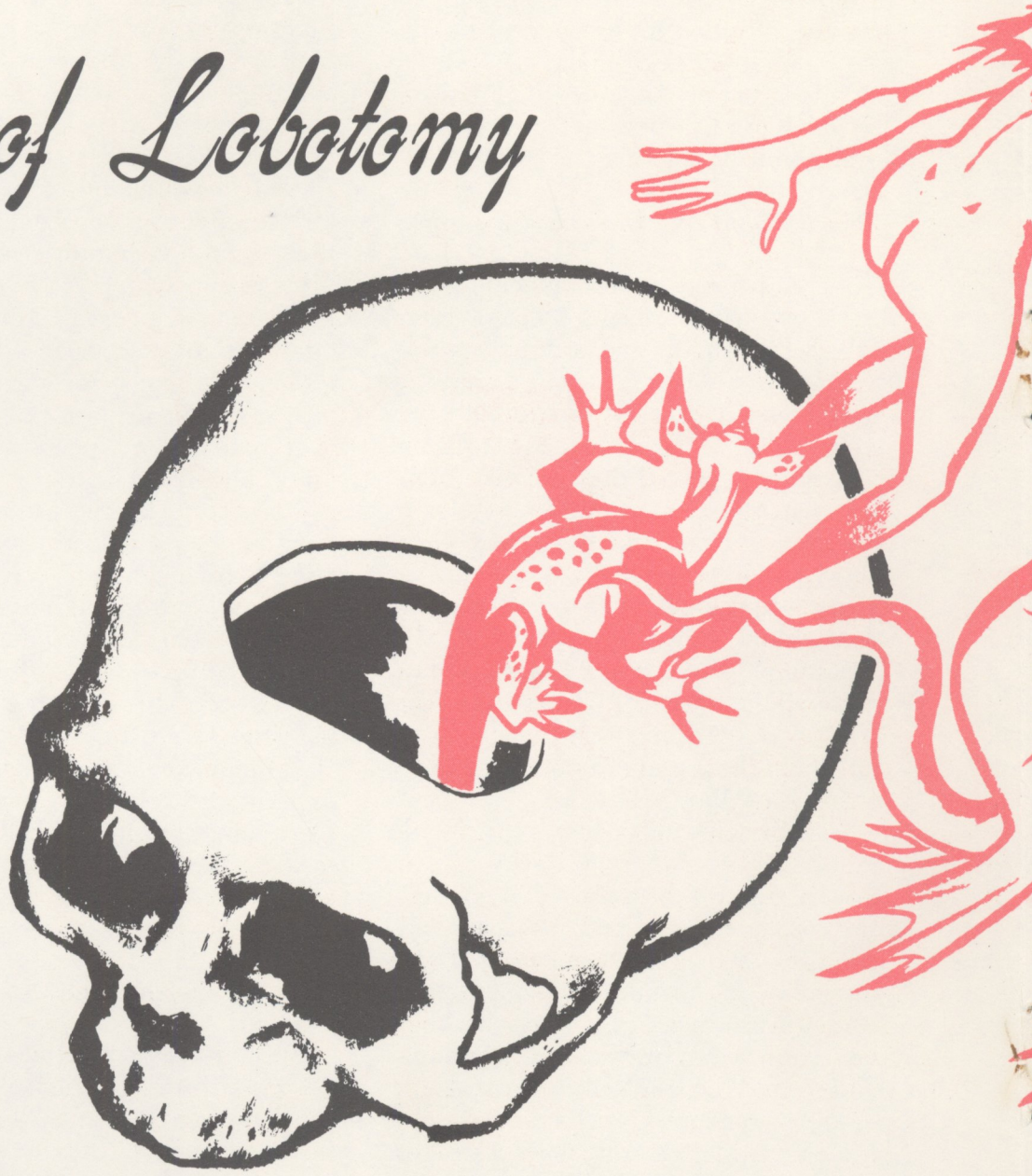
Re-evaluation of Lobotomy



RE-EVALUATION OF LOBOTOMY or leucotomy as a therapeutic method has become necessary since the dramatic successes with new drugs for treatment of patients with severe personality disorders. The use of drugs is based upon the hypothesis that a biochemical imbalance may be a major factor in the origin of psychosis. If a successful biochemical method in treatment is established, the use of neurosurgery which was begun probably before 3000 B.C. may become unnecessary. Both primitive societies and the highly developed culture of ancient Egypt utilized neurosurgery in a crude form. Early physicians acted, however, on a slightly different hypothesis from that of the modern neurosurgeon. They cut or ground holes in the skulls of their patients in order to allow the demons inside to escape. If the demons are identified with the psychosis, even modern advocates of lobotomy would agree that while behavior improves after operation, the psychosis generally remains, as does pain. Thus, the modern method is seemingly almost as ineffective as the primitive one for correction of the patient's basic difficulty.

Early experimental work was performed by David Ferrier, who, in 1875, described the effects of orbitofrontal ablation in monkeys. Gottlieb Burckhardt, the Swiss surgeon, some fifteen years later, performed four operations for mental illness. Burckhardt's patients survived, but without notable results. Puusepp, a Russian surgeon, in 1910 operated on three patients with no significant results.

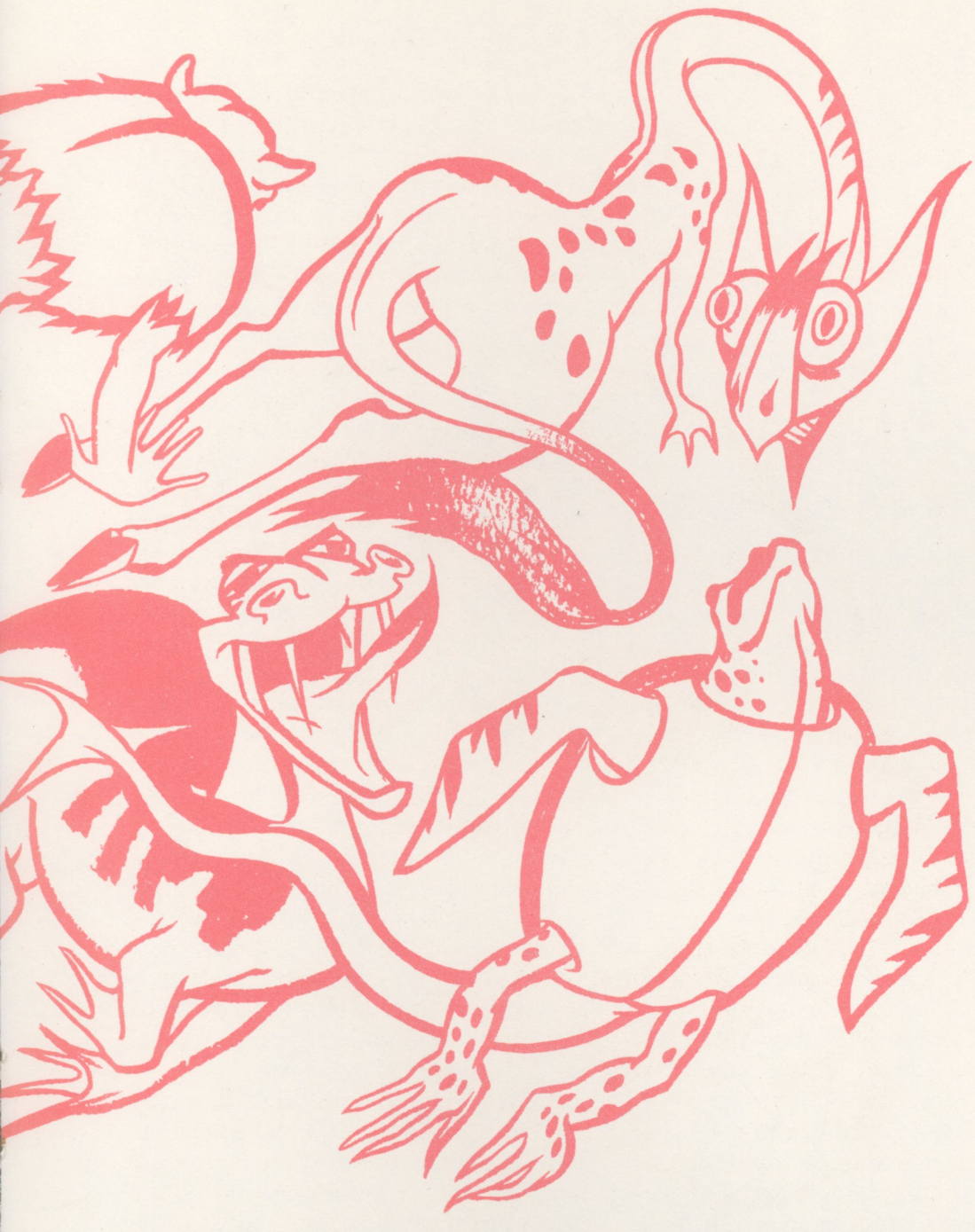
Fulton and Jacobsen, a Yale research team, reported experiments upon two chimpanzees, one docile, and the other ferocious and unmanageable. These investigators removed four to six cores of white matter from each frontal lobe in each chimpanzee, with resultant quieting of both animals and absence of their former characteristic frustrated behavior. Egas Moniz was in the audience of the neurosurgical congress in 1935 at which Fulton and Jacobsen reported their results. He arranged for a similar operation to be performed by Almeida Lima on carefully selected patients. These patients were chronic schizophrenics who had been hospitalized for many years. The nerve tracts in the frontal lobes were cut on both sides. Seven of these patients had been considered incurable but were able to leave the hospital after operation. Seven others appreciably improved, and six showed little change. Egas Moniz received the Nobel prize in 1949 for this contribution.

Walter Freeman, professor of Neurology at Georgetown University, became interested in the account of Egas Moniz' work and introduced the operation into this country. With his associate Watts, Freeman began to perform bilateral operations. The results were somewhat controversial in that, although the symptoms were alleviated, the patients when released from the hospital often developed other characteristics almost equally undesirable. The patients demonstrated some forms of regression and a general loss of learned behavior.

Lyerly and Poppen developed a more direct surgical approach. They performed lobotomy by making openings on both sides in the superior area, in line with the pupils of the eye and on the coronal suture. Incision was made frontally.

Fiamberti in Italy had begun performing transorbital lobotomy with a technique which Freeman introduced into this country in 1946. Electric shock was used in place of anesthesia, and the procedure involved less destruction than the earlier operation. Other modifications were introduced by Spiegel and Scoville.

Lobotomy, throughout the history of its use, has been a last-resort



kind of therapy, utilized only when such other techniques as psychotherapy, occupational therapy, electric shock, and insulin shock failed to restore or to quiet the patient. Pollack lists nine criteria for selection of patients for lobotomy. Among these are purposeful aggressive or sadistic tendencies; dissociative hysterical and hypochondriacal manifestations; any chronic functional psychosis, with paranoid manifestations; chronic psychotic states with mood fluctuations, purposeless excitements, or ones in which remissions occur spontaneously, or under electric shock, or are sustained by maintenance doses of electric shock or insulin.

Pollack found that the patients who respond best to lobotomy are those in active catatonic and paranoid states. Depressed patients, particularly those with ideas of suicide and self-mutilation are also suitable for operative therapy. Patients with involutional depression or with mental disorder as a result of cerebral arteriosclerosis have also been helped by lobotomy.

There is some difference of opinion as to the effects of lobotomy on personality. According to Kolb, the sense of individual responsibility for social conduct is lowered; and he also reported a general diminution of emotional reactions. He found judgment and initiative limited in such patients, with impairment of creativity. Although, according to Freeman and Watts, patients in such professions as dentistry, music, or medicine were never able to resume work at the former level after lobotomy, a recent article by Freeman mentions the return of a musician to his place in an orchestra after lobotomy.

Other problems of the most complex kind have required consideration before this operation with the possibility of far-reaching effects on the human personality can be evaluated fully. One issue is that of the responsibility of the physician toward his patient, in this instance toward that inner core of the patient, the essential personality. Involved with this problem is the patient's responsibility toward himself. There is a question of moral and legal responsibility inherent in a physician's use of measures which may alter the basic structure of the patient's personality. Suggestions have been made that a person who has undergone psychosurgery be considered only semi-responsible for his acts. Most physicians who have performed lobotomy extensively and worked closely with patients have expressed the conviction that psychosurgery should have more bearing on a patient's legal status than do other surgical procedures. To what extent similar problems will require consideration when such patients are treated by means of new drug techniques cannot yet be predicted. It is certain, however, that the new techniques do not have about them the irrevocability sometimes associated with surgery.

Kolb concluded that prefrontal lobotomy offers little to the majority of institutionalized patients; yet, the operation can sometimes restore to society patients who were formerly both disturbed and destructive. Such individuals, however, do not regain their full capacities; instead, they are extremely dependent, and their psychoses cannot be regarded as cured. It is to be hoped that the present and proposed experiments in biochemistry will afford more knowledge of the genesis of psychosis and will thereby make possible more effective and less radical forms of therapy.

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Raynaud's Disease

● In 1862, Maurice Raynaud first described the digital color changes that are now known, collectively, as *Raynaud's phenomenon*. His paper, a doctoral thesis, included this account: "Without appreciable cause one or many fingers become pale and cold all at once; in many cases it is the same finger which is first attacked; the others become dead successively and in the same order. . . . The determining cause is often the impression of cold . . . sometimes even a simple emotion is enough . . ."

The immediate cause of discoloration is vascular constriction, and the changes include cyanosis, pallor, and a wax-like pale yellow color. Discoloration may occur progressively or may be only a single change. As the vasospasm lessens, hyperemia produces rubor which lasts until the episode is over. A distinction is made between the terms *Raynaud's phenomenon* and *Raynaud's disease*, because the phenomenon occurs in several vascular diseases, as well as in diseases of the nervous system, chronic leukemia, scleroderma, and other disorders. Raynaud's disease, by definition, is limited to the disorder for which there is no demonstrable organic cause. Raynaud's disease is generally considered benign by comparison with diseases of which the phenomenon may be a symptom.

The exact etiology of Raynaud's disease has not been determined. Among the theories of causation are constitutional vasomotor instability, malnutrition (particularly calcium deficiency), and heredity. Bacterial, viral, allergic, or hormonal factors have not been established as pathogenic agents. It is known that the disease occurs most often in women in the third and fourth decades.

Blain, Coller, and Carver classified patients with Raynaud's disease into three clinical types: those whose attacks are precipitated only by cold; those who react both to cold and to emotional stress; and those whose attacks are initiated primarily by psychic distress. The prognosis for duration and severity of disorder was considered to be most favorable for patients in the first group, because usually they are able to avoid attacks, and the least favorable for members of the third group. Their illness is more likely to progress to tissue damage, and these patients will more often require sympathectomy. Unfortunately, even when sympathetic denervation is complete, the postoperative results are often poor for patients with emotion-induced attacks. The authors suggested personality appraisal, evaluation of vasomotor lability, and evaluation of capacity for intelligent cooperation in the care of patients with functional disease.

In personality appraisals, Mufson observed that patients with Raynaud's disease and scleroderma have in common a constant fear of loss of security. They are overly dependent individuals whose personal safety is contingent upon the abilities of another for protection. Such patients may continue without apparent physical disorder as long as the relationship is unchanged, but they are always vulnerable to the threat of alteration, and live in a state of anxious expectancy. If this dormant dread is confirmed by death of the protector, or by change in the life situation, the individual's tenuous control is inadequate. His inflexible behavior pattern precludes readjustment. In Mufson's opinion, fears of failure to adjust are expended upon the sympathetic pathways and minute vessels. Furthermore, as long as the patient feels that he is threatened by his situation, he will suffer attacks, and medical or surgical intervention cannot be effective until the psychologic problem has been ameliorated.

Millet, Leif, and Mittelmann have reported psychiatric investigation of four patients with Raynaud's disease. In each case, feelings of guilt about the death of a relative, or identification with a dead person had contributed to development of the disorder. Usually the initial attack had occurred after loss of a love object upon whom the patient had been overdependent. The authors cited fear of abandonment, resentment of desertion, fear of retribution, and a need for penance by partial self-destruction as dynamic factors. For example, one patient who felt intense guilt about her brother's death, stated that she must be punished and that the blanching of her fingers was somatic expression of this wish. Furthermore, she believed that only by death or by a symbolic approximation could she attain the love and attention her parents had given her brother.

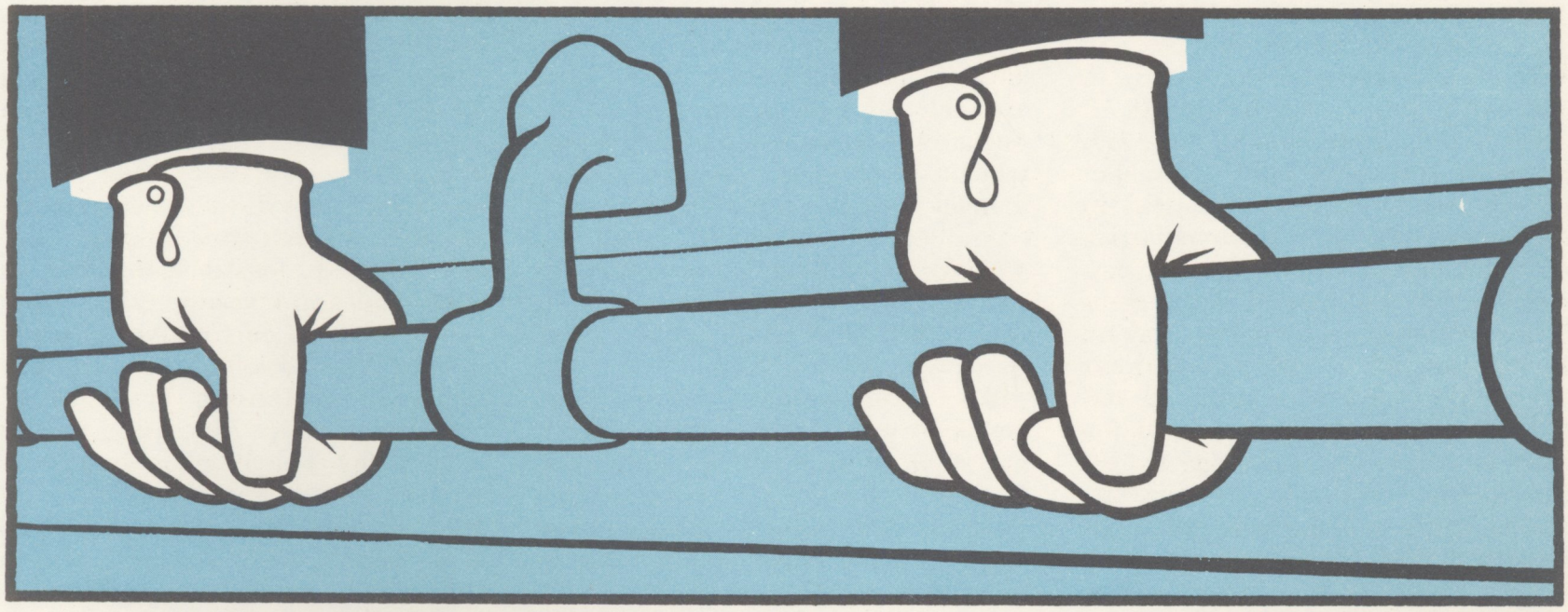
In a later report, Millet described the results of 112 analytic interviews with another of the four patients. This patient's mother, grandmother, two aunts, stepmother, and father had all died while she was living with them. In this instance, blanching of the fingers was considered to be a conditioned reflex which resulted from fear of contact with death. The original attack was a somatic response to fear, and later, repeated attacks became symbols of atonement for guilt-producing wishes. During three years of analytic interviews, the patient was able to expose repressed murderous, suicidal, and incestuous wishes, and to achieve limited insight into the mechanism of repression. However, she could not, at any time, recall masturbatory activity, although analysis showed that this had been a dynamic factor in development of guilt feelings. Touch and punishment, guilt and fear were all closely allied for this patient. During the time the patient was being treated, she worked as a volunteer nurse's aide at night. She explained that she wore a sweater to minimize tactile contact

with any patient who might be near death. After therapy was discontinued, the patient married a man, 22 years her senior, with whom she had been intimate for several years. Since then, for nine years, she has been free of digital discoloration, and feels secure in her status of matron in a small community.

Richardson reported an instance of Raynaud's phenomenon and scleroderma in which the patient's hands expressed her strongest emotions. She attributed great power to her emotions and feared them. The patient had felt rejected by her father, the dominant parent, during her childhood. As an adult, she had been accused, by her father, of responsibility for her mother's death. The patient developed a feeling of total responsibility for the welfare of everyone with whom she was closely associated. When a member of her family was ill or suffered a mishap, the patient reacted with feelings of guilt, fear, or rage, and with digital discoloration. For example, on one occasion when she believed that her daughter was not being properly cared for during an illness, the patient's hands became cyanotic and would not close. On another occasion, she prevented her young son from running into the street. As she stopped him, she thought that had he been killed, she would have been spared the burden of his care. The same evening her fingers were blanched. Subsequently, she taught her son to box, but became infuriated when he was involved in a fight at school, berated the teacher, and remained angry for several days. The patient expressed atonement for fantasies of manual destruction by selection of nursing as an occupation, and by a compulsive, perfectionistic housekeeping routine. Constructive activity performed with the hands seemed to assuage guilt and to serve as a defense against anxiety. After 27 months of intensive psychotherapy, symptoms were less severe, but x-rays of the essential lesions showed progressive tissue damage and increased absorption of the tufts of the distal phalanges. Three years after therapy, the patient experienced a schizophrenic reaction, of the catatonic type, and was later admitted to a mental hospital.

Despite the frequent incidence of particular attitudes in persons with Raynaud's disease, it is believed that nonspecific attitudes peculiar to the individual patient are equally important in formation of this symptom complex. In addition to understanding the symbolic significance of the symptom, complete investigation of the contributory emotional elements is necessary to effective therapy. Of four patients who were treated with psychoanalytic psychotherapy, Millet, Leif, and Mittelmann reported that two have been well for more than a year after therapy ended. Two who are still being treated have had reduction in attacks, and both severity and extent of involvement have diminished to a degree.

Millet and associates concluded that individuals with Raynaud's disease have a notable tendency toward conversion management of anxiety and obsessive-compulsive control of impulses. Each attack represents a substitute for direct expression of anxiety. In the opinion of the authors, many patients who suffer from this disorder could be benefited by psychotherapeutic management.



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Book Reviews

● The Meaning of Persons. *By P. Tournier, M.D. Pp. 238. Price $3.75. New York, Harper & Brothers, 1957.*

Another facet of the physician-patient relationship is delineated in this volume, by a Swiss psychiatrist, on the subject of the individual personality, particularly in its religious context. Readers of The Psychiatric Bulletin will be interested both by the author's unusual selection of references and by his discussion of the interaction of mind and body in different states of disease.

Tournier's book includes quotations from such diverse sources as Boehme, Gosse, St. Matthew, Bergson, Bernard, and Buber, to name only a few. The volume is indexed, and was translated by E. Hudson from Le Personnage et la Personne, published by Delachaux & Niestle.

● The Child Within the Group. *By M. E. Turner. Pp. 93. Price $3. Stanford University Press, 1957.*

This volume is subtitled "An Experiment in Self-Government" and, as such, it affords an interesting example of one particular way to assess behavioral development and social adjustment in young children. The author has worked both in school systems and in Child Care centers and from her experience has developed this experimental procedure to elucidate some of the group standards evolved by children in the years between four and nine. Literal reports of the children's own conversations are included, which definitely are informative as to the age levels at which socialization and purposeful management become apparent.

● The Religious Dimensions of Personality. *By W. E. Oates, Th.D. Pp. 320. Price $4.50. New York, Association Press, 1957.*

To current studies of theories of personality the author adds his interpretation of the whole personality from the standpoint of spirituality or religion. The historical development of psychologic study of man is outlined briefly, and comments of philosophers, theologians, and physicians are cited in their historical sequence of contributions. This book is indexed and has an extensive bibliography.

● Child Psychiatry. *3rd ed. By L. Kanner, M.D. Pp. 777. Price $8.50. Springfield, Charles C Thomas, 1957.*

The new edition of this extremely useful volume is presented in the same order and arrangement as the earlier ones. There are, however, additional materials and references. A brief chapter with an excellent bibliography has been added on the subject of drug therapies, and there is a new, short section on separation anxiety. The chapter on anxiety attacks has not been changed nor new material added. There are interesting changes in the sections on obsessions and compulsions, structural disorders, and schizophrenia. The volume has both subject and author indices, the latter of which is greatly augmented. The section on the subject of anorexia nervosa has been rewritten, shortened, and different authorities have been cited.

● Anatomies of Pain. *By K. D. Keele, M.D., F. R. C. P. Pp. 206. Price $5.50. Springfield, Charles C Thomas, 1957.*

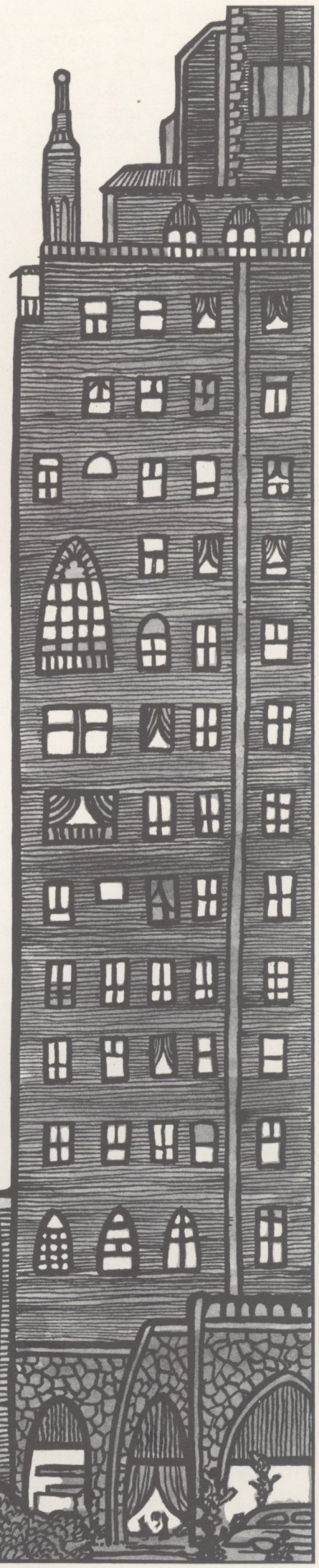
Although the earliest of medical practitioners were aware of the existence and importance of pain, the concepts of source and transmission have changed greatly from one generation to another. The development of interest in pain and of current opinions as to the physiologic processes involved is the subject of this unusual and stimulating volume. There are 27 illustrations, references grouped by chapter, and separate indices of subjects and names. The idea of the Sensorium Commune, from Aristotle and Plato, through William Harvey, and to the Victorian researchers is of especial interest. The author's style, familiar from his other historical contributions, affords pleasant reading throughout and promises instructive material besides. This book is published simultaneously in Oxford, by Blackwell Scientific Publications, Ltd., and in Toronto by The Ryerson Press.

● Pediatric Profiles. *Edited by B. S. Veeder, M.D. Pp. 267. Gift to subscribers to The Journal of Pediatrics. St. Louis, C. V. Mosby Co., 1957.*

Readers of The Journal of Pediatrics will enjoy having the articles from the department "Pediatric Profiles" from November of 1953 until November of 1957 in collected form. This group of 30 biographical essays is arranged chronologically in order of birth dates of subjects, and there are two additional historical sketches by Bela Schick, M.D. and B.S. Veeder, M.D. The volume is illustrated principally with photographs of the pediatricians or of portraits of them, but there is also a crayon portrait of Rurah (and some of his verse) as well as a delightful cartoon by Sunderland of Blackfan, making the rounds of the wards. There are 29 authors represented in this collection and the name index includes both them and their subjects.

Bases for Psychiatric Referral:

THREATS OF SUICIDE



● SELF-DESTRUCTION is almost always preventable because only rarely does an individual commit suicide without previous disclosure of intent. Unfortunately, one of the most obvious warnings is frequently overlooked. The person who speaks of a wish to die, or, less directly, of the burden he is to others, of worthlessness, or of futility, is often simply disbelieved. Actually, such statements should never be disregarded, because admission of suicidal thoughts may be sincere and purposive.

A significant percentage of suicides could be averted by recognition of indications, preventive measures, and continued care. Few persons who commit suicide would be certified as actually demented. Whatever the mental state at the time of the attempt, the immediate impelling emotion is usually depression. The mechanism is described by Fenichel as an inward turning of hostility previously directed toward another person. Apparently, the wish to live depends upon maintenance of a degree of self-esteem and upon the support of the superego. Suicide may be attempted because maximal submission seems to be the only recourse; or, less passively, suicide may be an act of rebellion to force reconciliation of ego and superego, whatever the cost.

A different mechanism, noted by Fenichel, is that in which the thought of death is associated with pleasant fantasies. In this instance, suicide is the result of a displaced emotion. Examples of this displaced emotion are hope of reunion with someone who has died, identification with a deceased person, or simply the idea that death provides gratification.

Batchelor has described a gradient of despair which extends from transient thoughts of suicide, to expression of such thoughts, to unsuccessful attempts, and, finally, to actual suicide. Unquestionably, many persons think of suicide during periods of intense stress, but relatively few express these ideas verbally or by overt action. The individual who speaks of suicide has, therefore, made an additional significant gesture within this gradient.

Occasionally, threat of suicide is made from pique, or in effort to change the behavior of an associate. Although the immediate precipitant may seem trivial, an impulsive suicidal act can result. The individual who wishes to change another person's behavior by threat of suicide, the one who demonstrates defiance, and even the person whose threat is obviously histrionic all need in some way to alter their environments.

In many instances, the patient does not speak of his intention. Prevention, in such cases, depends upon the observer's alertness to other signs. For example, indications of depression include early morning insomnia, anorexia, weight loss, persistent constipation, amenorrhea, and loss of sexual inclination. Frequently, the

patient complains only of physical disorder, and, if organic cause is not found, the possibility of depression should be considered. The emotional patterns include lack of interest and initiative, self-depreciation, guilt, and, sometimes, fear. It should also be remembered that the presence of organic disorder does not necessarily preclude serious depression.

A patient may be asked indirectly about suicidal intent by general questions about plans for the future. Careful study of the history will be helpful. For example, although suicide is, of course, not heritable, there is greater risk with a family history of suicide. The reason may be morbid identification with a relative who committed suicide. Another significant factor is a history of alcoholism. In almost one-third of suicidal attempts, alcoholism has been directly or indirectly causative. Finally, physical illness may cause discouragement and lowered emotional resistance. It is interesting to note, however, that persons who are gravely ill do not usually commit suicide to escape pain; instead, the motive is more likely to be removal of the burden of their care from relatives.

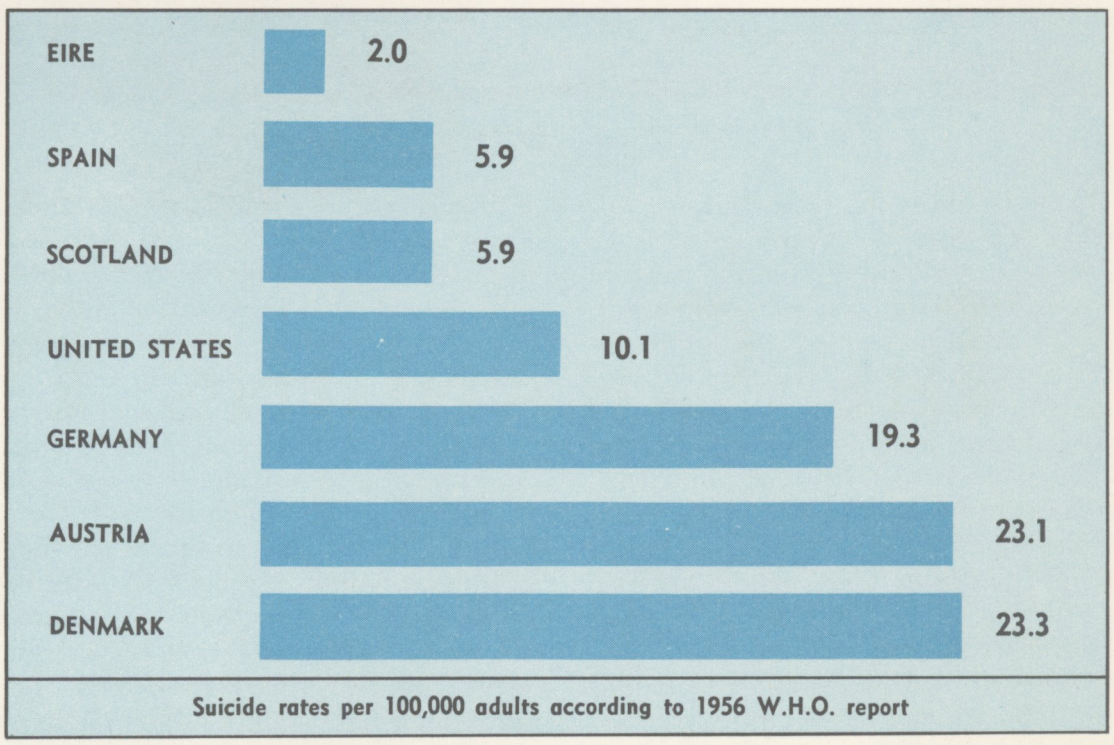
Such events as bereavement, unwanted pregnancy, or loss of employment may cause suicide, although such reaction to distress occurs in persons who are immature or abnormal. According to Hendin, in these instances, self-esteem had been dependent upon the lost object or the status before the altered circumstance.

Suicide has been ranked ninth to eleventh among causes of death in this country. Undoubtedly, such figures represent understatement, since many suicides are reported as accidents or are attributed to other causes.

Self-destruction is not as commonly associated with neurosis as with psychotic disturbance. A common exception in neurosis is the suicide that results from homosexual panic reaction. In psychoses, suicide may be part of a major dissociative reaction. For example, a schizophrenic may commit suicide because of anxiety.

The most significant aspect of management of potentially suicidal patients is recognition of the different indications, as well as knowledge that a suicidal threat, whether it seems sincere or not, cannot be lightly dismissed. Attempts to cajole or argue will not alter the problem; nor does recommendation of a vacation effect any change. The physician may help the mildly depressed patient toward more hopeful adjustment to his environment, but if there is no indication of progressive improvement, the patient should be referred for immediate psychiatric care.

A sudden mood change from severe depression to a serene outlook may be indicative of a decision to commit suicide. Another factor is the frequent occurrence of suicide after a patient has partially recovered from depression and is seemingly more adequately adjusted. A study was reported by Moss and Hamilton of 50 patients who had made serious suicidal attempts. The plan for their care was divided into three phases: management during acute illness, convalescence, and recovery. During the acute phase, therapy included protection, relief of anxiety and guilt, and elimination of solitude by occupational and recreational therapy. The authors observed that many patients felt increased anxiety after the attempt because of fears of retaliation and rejection. The physician explained the act to the patient as an effort to solve an overwhelming problem. In the convalescent period, solution of the problem was discussed more specifically. The physician planned with the patient's relatives, friends, and business associates to provide the best milieu possible for the patient's return. During the recovery phase, overnight and weekend visits were permitted. Despite careful preparation, four-fifths of the patients reported reactivation of suicidal ideas, and, in 55 per cent of the group, the ideas were extended to suicidal gestures. Continued therapy was provided in the hospital and for six months after discharge. Follow-up study averaged six and one-half years, and, at the time of the last follow-up report, 50 per cent of the patients were considered recovered, and 20 per cent of them were greatly improved.



Suicide rates per 100,000 adults according to 1956 W.H.O. report

Suicidal threats, gestures, or attempts are indicative of profound emotional disturbance. Usually, the suicidal idea is only one aspect of maladjustment, but the patient must be helped to allay such thoughts before treatment for concurrent disorder.

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The Changing Neuroses

● According to Christensen, neuroses prevailed in the 19th century and character disorders in the 20th. In World War I the most frequent symptom formation in officers was psychasthenia and, in enlisted men, hysteria, or, as it was later called, conversion reaction. In World War II anxiety states were the most common in both categories.

With the impetus provided by two world wars, psychiatric concepts were suddenly re-evaluated, clarified, extended, and drastically altered. Modern psychiatry began with the descriptive classification of symptom complexes. Entities were designated by their observable features and subjective symptoms. It soon became apparent, however, that mental disorders were not invariably demonstrated according to description, nor the course of disease always predictable by classification. Psychoanalysis made possible a method for study of emotional processes and their relationships to behavior. The change from descriptive to dynamic psychiatry thus resulted in a wider concept of mental disorder. More flexible criteria for evaluation provided opportunity for considerable diversity of opinion, and for exceedingly varied terminology. Medical schools, clinics, and hospitals throughout the country used different nomenclatures, and, although communication was somewhat impeded, it was not until the Second World War that the confusion and inadequacy of psychiatric terminology was fully recognized. Even the principles which had been acceptable in psychiatric management of servicemen during the First World War were no longer tenable.

During World War I, American psychiatry was still, essentially, in the descriptive phase, with emphasis upon the likelihood of organic causes for mental disorder. The term "shell shock" was first used to describe the results of cerebral hemorrhages caused by exposure to exploding shells. For several reasons this usage was later discarded, as gross brain injury was exceptional, persons who had not been exposed to battle conditions developed "shell shock," and the wounded only rarely evidenced comparable disturbances.

Nomenclature was still a problem in World War II. "Shell shock" was, of course, outmoded. To emphasize the psychological factors in mental disturbances the terms of civilian psychiatric practice were employed. As Glass pointed out, with this method a diagnosis of neurotic disease became fixed when, in many instances, the disorder was transient. Therefore, in 1943, the term *combat exhaustion*, and the corollaries, *combat fatigue*, *flying fatigue*, and *operational fatigue* became popular. Implicit in these designations was the idea that such reactions might occur in either neurotic or non-neurotic persons. However, after the terms had been used for a time, their original meaning was also obscured. Once again, emotional reactions to combat were considered to be the result of organic dysfunction. Finally, after the Korean War, The Committee on Nomenclature and Statistics of the American Psychiatric Association approved the term *gross stress reaction* to specify transient emotional disturbances, with two subheadings, *combat*, and *civilian catastrophe*.

Four decades of intensive research resulted in recognition of the need to distinguish normal and neurotic psychologic processes. Kubie has suggested an explanatory hypothesis. He described neurotic development in these three stages: the neurotic potential, process, and state.

The neurotic potential is seemingly peculiar to man and results from the ability to represent abstractions in symbols. Two symbolic functions are self-expression and communication by use of language, and the unconscious effort to allay anxiety by symbolic methods of self-deception. These two are related, have a common origin, and are necessary to the representation of internal experience. The essential difference is in the awareness of the relationship of the symbol to the psychologic function in language, while, in expression of neurosis, the unconscious psychologic function is inaccessible.

The neurotic process begins with repression of the thought of a painful psychologic experience. Afterward, only a symbol in the form of a pattern of behavior, thought, or feeling remains evident. The process is complex because, as more problems are repressed, they may be represented by the same symbol or by others. Kubie called this the stage of *masked neurosis*, and stated that it may continue for as long as the symbolic behavior does not disturb the individual. Even though the individual does not recognize the neurotic process as harmful, the behavior pattern could, however, adversely affect other persons.

The neurotic state is that of clinical neurosis in which the individual recognizes a behavior pattern that disturbs him, and about which he is likely to consult a physician. According to Kubie, clinical neuroses are far less prevalent than the masked neuroses which have, therefore, greater significance to society.

In all psychologic function there are elements of conscious, preconscious, and unconscious stimuli. For example, behavior that is stimulated by mostly conscious forces is flexible in that it can be altered in accordance with reality. In contrast, behavior that is dominated by mostly unconscious forces, or by preconscious and unconscious alliance, is not under voluntary control. Since the symbolic goals are unattainable, the unconsciously motivated behavior will be repeated even if incompatible with reality. The first process, then, may be considered evidence of normalcy, and the second a neurotic process.

The term *character disorder* was adopted during World War II, after it was recognized that the categories of psychosis, neurosis, and psychopathic personality did not properly connote the most prevalent mental disorders. Character disorder is manifested as a deviant behavior pattern, with minimal outward indication of the anxiety usually observed in neurosis. The reason for this seeming lack of anxiety is that the deviant emotional response is ego-syntonic, or acceptable to conscious evaluation. In contrast, the symptoms of neurosis are ego-alien, and usually cause distress. The initial conflict is, of course, ego-alien in both cases, and is repressed. The psychiatric approach to such patients includes character analysis instead of direct therapy.

Although character disorder is not listed as such in the American Psychiatric Association's Diagnostic and Statistical Manual for Mental Disorders, the equivalents are enumerated in the section entitled "Personality Disorders." There are four major headings and 19 subheadings in this category. In extensive surveys of military personnel, classical neuroses were rare in contrast to frequent incidence of character disorders. It is also believed that character disorders predominate in civilian practice. The 1957 report of the National Committee Against Mental Illness showed the percentage of first admissions to mental hospitals as 4.7 per cent psychoneuroses and 11.6 per cent personality disorders.

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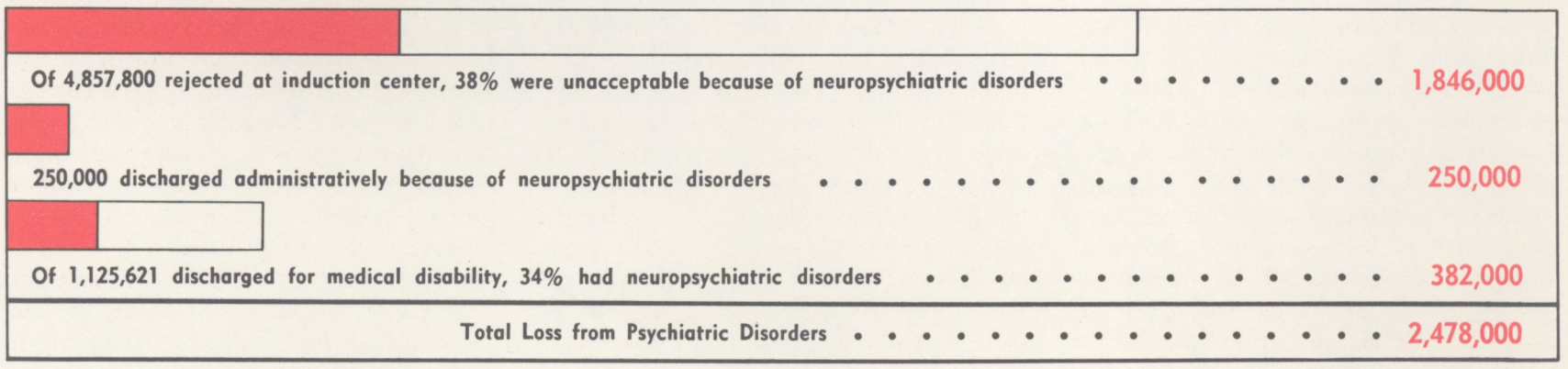
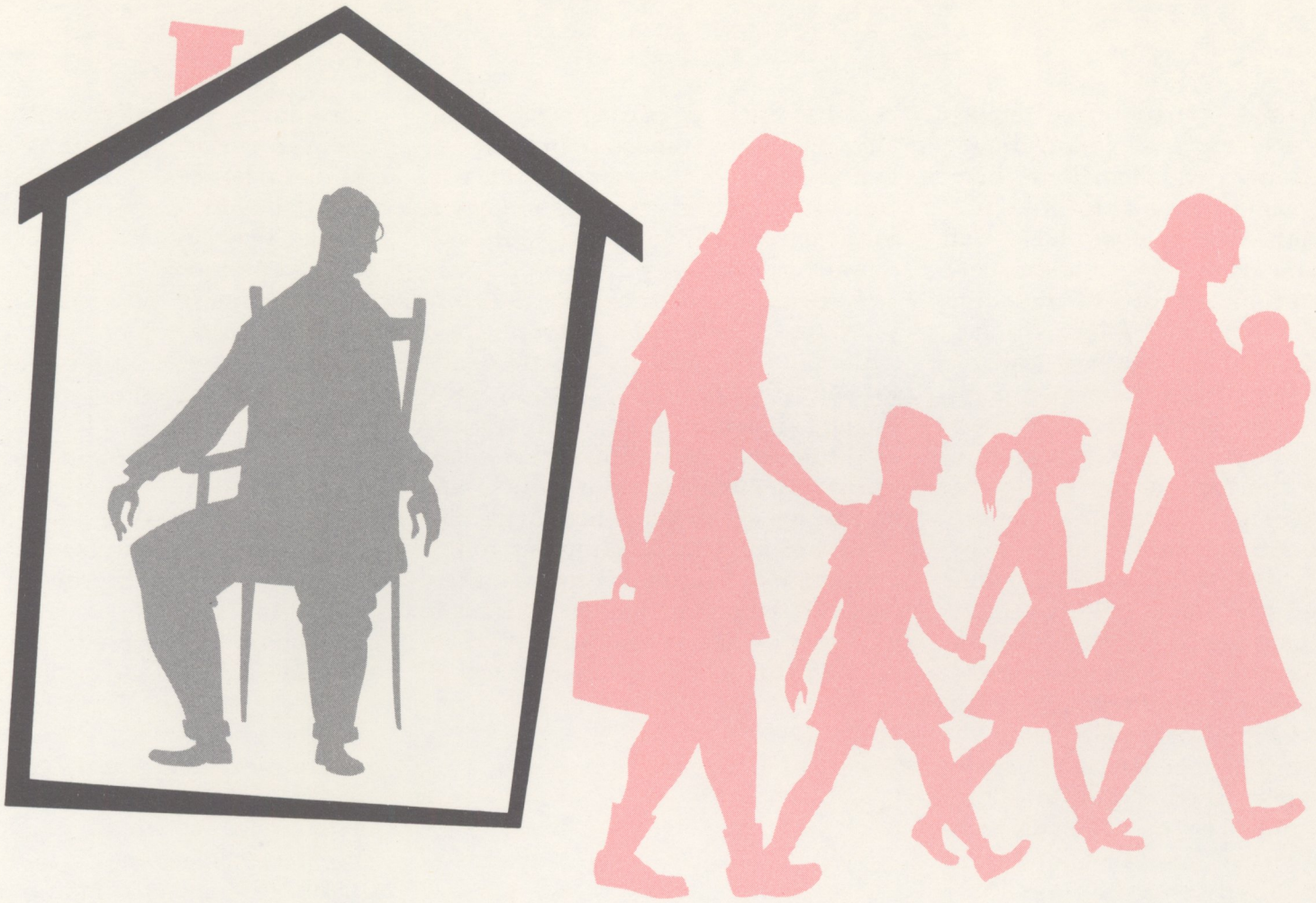


Based on studies of 15,000,000 examinees for military service, World War II

Adapted from Menninger, W. C.: Facts and Statistics of Significance for Psychiatry, Bulletin of the Menninger Clinic 12:1 (Jan.) 1948. Adapted by permission of author and publisher.



Problems of DEPENDENCY

ENFORCED DEPENDENCY affects the family more drastically than has been previously recognized. Understanding of the reasons for prevalent disturbances in the geriatric population, and acknowledgment of the problems are prerequisites to correction of the situation.

During the past 50 years, it has been established that adequate emotional preparation for old age begins with successful resolution of childhood conflicts. Many geriatric patients were subjected as children to severe parental restriction, discipline, and, perhaps, seeming rejection. Emotional conflicts were repressed, and adult adjustment was accomplished by defense mechanisms. With old age, repressions are reactivated, and often the defensive measures are no longer effective. Other defenses which develop in later years in such individuals may include irritability, suspiciousness, hoarding, resistance to change, and hypochondriacal strategies. These symptoms have been commonly regarded as characteristic of old age, when actually, they are forms of defense against anxiety.

One of the most common emotional disorders of old age is depression. A contributory factor may be the cultural pattern of overemphasis upon youth and devaluation of age. Because of this, elderly individuals who helped in youth to strengthen this concept, are forced, as they age, to self-rejection, with inner-directed hostility that results in loss of self-esteem and in depression.

The reaction of shock and distress in recognition of self-aging is rarely anticipated. The individual tends to withdraw and isolate himself, and to strive for reassurance by constant, zealous testing of vital functions. Deliberate isolation, as well as the isolation produced by diminished sensory acuity, results in a distorted awareness of environment.

The emotional problems of elderly individuals are neither inevitable nor irreversible. For many years, it was believed that clinical manifestations of personality disturbance were in direct ratio to the degree of senile cerebral damage. This theory has been disproved. For example, at autopsy, not all elderly persons with severe emotional disorder are found to have causative brain damage, and, conversely, extensive organic deterioration has been found in well-adjusted elderly persons. The reversibility of personality disorders after environmental change and supportive psychotherapy has also been shown.

Family interaction

Two-thirds of the geriatric population are dependent upon relatives for support and care, although social agencies exist to help with the problem. The exact nature of the problems and the effect upon family stability are less well-known.

First, the financial aspect is a major concern in many families. The cost of support and medical care, and the necessity for larger living quarters may be prohibitive, particularly if the family must at the same time be responsible for care and education of younger members. In many cases, this dual responsibility can be fulfilled only by a reduced standard of living for the entire family.

Second, and perhaps more important, is the effect upon family interaction in homes which include three or four generations. The difference in outlook between the older and younger members often causes tension and lessens ability to maintain stable relationships. More fundamental than this, however, is the actual change in identity which takes place in elderly parents and their grown children. The assumption of responsibility is reversed; the elderly parent becomes dependent, and the child assumes the role of protector. This is an especially difficult transition for the older person. It tends to confirm his self-devaluation and conviction of uselessness. As a defense, the elderly individual often becomes demanding and expects his grown children to obey, ask advice, and comply with every wish. This, in turn, provokes hostility, so that the situation becomes a major factor in the instability of many families.

Marital adjustment in old age is governed by several factors. Generally, marriages that have been satisfactory throughout life continue to be so, and those which have been less than satisfactory are likely to deteriorate as outside interests and activities decrease. Occasionally, a relationship evolves which Meerloo called a form of "sibling rivalry." In this situation both persons are in competition to attain the greater amount of attention and pity.

Sexual relationships are also significant. The sexual activity of elderly persons varies greatly with individuals, as attested by divergent findings in reported investigations. For example, Busse and others stated that, in a study of 70 persons who were more than 60 years of age, 28.6 per cent were sexually active. In contrast, Kinsey reported 70 per cent sexual activity in a group of 87 males who were 70 years old. Recognition of individual variance is necessary to provide adequate counsel and to avoid creation of conflicts. For example, a 68-year-old widow who planned to be married was told by her physician that sexual activity must stop after the age of 50.

Physician-patient relationship

A different kind of transference takes place in the care of elderly persons, since, in most instances, the physician is younger than the patient. Because the patient finds it difficult to accept a younger person as a parental figure, resistance to therapy is relatively frequent.

Two important factors are necessary for a satisfactory therapeutic situation. The first is the necessity to help the patient maintain self-esteem. Resistance to guidance usually results from feelings of hostility toward the environment which are caused by self-directed hostility. The second is provision for future contact. Even though maximal adjustment has been attained, the patient will usually require the reassurance of periodic visits or some other form of

communication. Another factor which may affect the care of geriatric patients is that of countertransference. The physician may find in his own attitude a reflected ambivalence toward parental or surrogate figures.

Economic and sociological implications

In this country there are approximately 14 million persons who are more than 65 years of age. Many of these individuals are employable, but, because of regulations on employment age limits and compulsory retirement policies, occupational usefulness is denied to them. As the geriatric population continues to increase, the financial aid provided by old age assistance programs will reach an irreducible minimum. It would seem that, since elderly individuals were employed successfully during the war period, there must be some solution, besides this, in which the skills of older persons could be utilized. The present-day paradox of young employees' requesting shorter working hours and more days of leisure, while older persons must accept enforced leisure represents unbalanced allocation of work and time.

Conclusion

According to Williams and Jaco, ". . . a complete re-evaluation of current thinking regarding mental illness in later life is needed. . . . Role obsolescence or outliving one's usefulness as defined socially, with a consequent loss of personal significance and meaning, may be one of the most important aspects of mental illness in later life. The relegation of the older person to a condition of enforced dependency, with consequent loss of individuality and autonomy may be a significant factor."

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Biochemical Research in Schizophrenia

● In experimental studies, Bercel has tested the effects of blood serum from schizophrenic patients in spiders of the species Zilla-X-notata. The test group included 70 spiders. After a pre-test period of spinning perfect webs, the spiders were fed flies which contained blood serum taken from schizophrenic patients. The perfect webs were destroyed, and the spiders' reaction to the serum was evaluated by their web replacements.

Especially dramatic results were shown after ingestion of serum from catatonic donors. The spiders evidenced catatonic-like behavior, became listless, and were relatively immobile. Their new webs consisted of only a few asymmetrical strands in contrast to previous intricate web patterns.

Bercel and his associates plan to test the spiders with serum from cured schizophrenic patients. Then, if the spiders spin perfect webs, it would indicate that some change occurred in the blood chemistry of cured schizophrenic patients.

In another study, Heath and his associates have reported the discovery of a specific protein substance peculiar to the blood of schizophrenic patients. The substance, called *taraxein* from the Greek *taraxis* (mental disorder), has been extracted from the serum of schizophrenic patients and administered to normal subjects who then demonstrated schizophrenic symptoms for periods of one to two hours. The authors described their publication as a progress report and stated that the investigation is not yet complete, nor are the findings conclusive. The results of this experimental work are, however, indicative of a biochemical influence in the development of schizophrenia. Tentatively, the experimental findings show that schizophrenia is a single disease entity, and that the schizophrenic patient's ability to detoxify taraxein, or a product of its chemical action upon another component, is deficient. Heath and associates have additional studies in process, the results of which will be reported later.

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"The mind is its own place, and in it self
Can make a Heav'n of Hell, a Hell of Heav'n."
Milton, 1667